COMMENTARY

Opioid-Related Emergency Department Visits and Access to Health Care—An Opportunity for Treatment Engagement

THE UNITED STATES is in the midst of an evolving opioid epidemic, involving drugs ranging from prescription opioids to illicit and synthetic opioids such as heroin and fentanyl. Drug overdose is now the most common cause of death in the United States, and opioids are involved in almost half of these deaths, with opioid-related overdose deaths increasing by more than threefold in the last decade (Centers for Disease Control and Prevention [CDC], 2019). Unfortunately, among individuals with opioid use disorder (OUD), treatment is underutilized (Novak et al., 2019). A significant proportion of individuals with OUD are uninsured, and affordability is the primary reason for patients with OUD to forgo treatment (Novak et al., 2019). Research has shown that insurance coverage is a major factor in whether patients who need treatment are able to access it, especially in the context of the opioid crisis (McKenna, 2017).

OUD imposes a considerable financial burden on states, with Medicaid programs paying more than $70 billion over the last decade in opioid-related health care costs (Leslie et al., 2019). In this issue of the *Journal of Studies on Alcohol and Drugs,* Grossman and Hamman (2020) document how partial Medicaid expansion in Wisconsin (childless adults age 19 and older and below 100% of the federal poverty level) was correlated with an increase in opioid-related emergency department visits, particularly among men ages 30–49 and among women ages 19–29. The article highlights an issue that is at the forefront of the policy response to help curb the opioid crisis—how would patients with OUD without prior access to health insurance coverage interact with the health care system once they have access to it? As Grossman and Hamman (2020) show, gaining Medicaid coverage led to an increase in opioid-related emergency department visits. The authors correctly point out that this increase in emergency department visit is not attributable to an increase in opioid prescriptions because of health insurance coverage but rather the result of a lack of care when individuals were uninsured. Difficulty in finding behavioral health treatment has been widely documented in the literature (Covino, 2019); thus, it is plausible that when individuals gain coverage, they go to the emergency department because of the difficulty in finding a provider who would accept their health insurance. Research has shown that individuals with mental health conditions who gained health insurance coverage continued to face significant barriers in accessing health care regardless of the type of health insurance (McKenna et al., 2019). Narrow provider networks have been suggested as one reason for this barrier to care (Zhu et al., 2017). However, barriers to care among individuals with OUD who gained health insurance coverage is still unexplored in the literature.

Research has shown that outpatient treatment with naltrexone/buprenorphine is associated with long-term engagement with treatment programs and high rates of opioid abstinence (Mancher & Leshner, 2019). Furthermore, office-based treatment with buprenorphine has the potential to significantly increase access to treatment for OUD (Mancher & Leshner, 2019). Thus, an opportunity exists for emergency departments to play a crucial role in connecting patients to treatment. In fact, research has shown that emergency department–initiated buprenorphine treatment resulted in a greater percentage of patients with OUD being engaged in treatment compared with patients who were just provided a referral (D'Onofrio et al., 2015). To connect patients with ongoing care, some states have implemented programs that allow emergency departments to facilitate "warm-handoffs" to specialized treatment providers, including hospital-based bridge clinics and community-based outpatient providers (Hospital Association of Pennsylvania, 2019; Samuels et al., 2018). However, a little over 10% of the patients with an opioid-related hospitalization or emergency department visit receive any U.S. Food and Drugs Administration–approved opioid dependence medication within 30 days following discharge (Naeger et al., 2016)—a missed opportunity in the fight against the opioid crisis. Thus, the increase in patients seen in emergency departments for opioid-related conditions identified in Grossman and Hamman (2020) are potential openings to connect these patients to the care they need.

Emergency departments are an important component of the U.S. health care system and have a vital role to play in the fight against the opioid epidemic. Indeed, the findings from Grossman and Hamman (2020) imply the importance of follow-up treatment and the crucial role the emergency department can play in facilitating that. This may require

additional system-level support, such as financial incentives and performance measurement, to promote regular initiation of follow-up care by emergency departments.

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